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PURULENT PERICARDITIS.*

G. M. GRAY, M.D., KANSAS CITY, KANSAS.

The subject of this paper has been suggested to me by a case that came under my care a few months ago, and which I presented before the Academy of Medicine of Kansas City, Mo., a few months ago.

Purulent pericarditis is a rare condition, and one in which the symptoms have not as yet been well studied. As far as we are able to determine the symptoms of pus in the pericardium vary in no way from the symptoms presented in other effusions in the pericardial sac, and the diagnosis can be definitely determined only by the withdrawal of some of the contents. The symptoms of effusion into the pericardium vary somewhat with the quantity, and the rapidity with which it accumulates. But the amount of fluid that can be endured and not destroy life is sometimes many quarts, as in the case that I will refer to later on in which I withdrew fifty-five ounces by aspira-

* Read at the Thirty-sixth Annual Meeting of the Kansas Medical Society, Lawrence, May 7-9, 1902.

tion. And there is a case on record in which sixty ounces of pus were withdrawn.

In the normal condition the heart extends from the third to the sixth costal cartilage, and from half an inch to the right of the right border of the sternum, to a point half an inch to the right of the left nipple. The pericardium is of a somewhat conical shape—its base resting upon and taking firm attachment to the diaphragm, while the upper, narrow part surrounds the trunks of the great vessels at the base of the heart. Collections of fluid within the pericardium distend the pericardium and increase the area of normal heart dullness in all directions—the position of the heart being little if at all changed—the apex beat will probably be lost entirely, or in smaller effusions pushed up, heart sounds muffled and indistinct. Dyspnea, praecardial oppression, feeble, irregular pulse, difficulty in deglutition, dilation of the cervical veins, cyanosis, and increased area of cardiac dullness.

These symptoms may arise from any effusion in the pericardium. The removal of serous effusions from the pericardium—paracentesis of the pericardium—is usually accomplished by aspiration, the needle of the aspirator being introduced through the fifth intercostal space at a point two inches to the left of the left border of the sternum, which is external to the internal mammary vessels. Roach advises tapping on right side of sternum. In purulent collections within the pericardium the diagnosis can only be made with absolute certainty after examination of contents, and where the collection is large may be resorted to as a means of temporary relief from dangerous symptoms but never should be relied upon as a means of cure. Here the means demanded for cure of the diseased condition, are the same as in collections of pus in other cavities, such as empyema of the pleura. Purulent pericarditis is much more frequent in childhood, and occurs in the new-born as a result of infection of the cord, and at times follows periostitis, ostitis, tonsilitis, pneumonia and purulent pleuritis. The tendency to effusion is greater in the child than in the adult, and is more likely to be purulent. Primary and uncomplicated cases are rare and for this reason it is impossible to formulate a practical general symptomatology for the disease. The following case I attended with Dr. Nason of Kansas City, Kansas, in August, 1900.

C. L., age 16, employed by S. S. Packing Company. Father and mother living and in good health. Has enjoyed good health but suffered from rachitis during early childhood, resulting in great deformity of the long bones in vicinity of large joints.

History of the Attack—After two or three days of general malaise

with some difficulty in breathing and shortness of breath, on exertion or in talking. On July 9th, while at work, was attacked with very severe pain in chest and great difficulty in breathing, and vomited; was so ill that he was removed in carriage to his home where Dr. Nason was called to attend him. The pain in chest, dyspnea, nausea and vomiting continued for one week during which time there was elevation of temperature, never high.

At the end of one week there was some abatement in these symptoms, and he was allowed to sit up; but on the ninth day had chill and began to grow worse with increased dyspnea and pain, required constant fanning. The surface of the body was constantly cool and for three days prior to my first visit (July 30, 1900) temperature had been subnormal. At this time temperature was 96 degrees and pulse could not be counted, as it was irregular, feeble and very rapid. There was marked cyanosis and edema of extremities, more marked about ankles and greatest on right side; he lay on the back without pillow and required constant fanning. Could be turned onto right side, but was very uncomfortable when on the side. My examination was made while he was in this position. On inspection of chest, anteriorally there was marked fullness of left side, with precardial bulging. Percussion elicited increased area of heart dullness. There was flatness extending beyond the right border of sternum, and on the left side to the posterior axillary line; but there was not the flatness on percussion posteriorally that we would have in case of large pleuritic effusion. On auscultation the heart sounds were muffled and indistinct, respiratory murmur heard over upper part of left chest above third costal cartilage anteriorally and over scapular region posteriorally. From these symptoms and the condition of the patient, I diagnosed the case as one of pericarditis with large effusion, and advised immediate aspiration, as his condition was such that death might occur at any moment. So, after procuring aspirator and preparing the patient by thorough scrubbing of chest with soap and water and sponging skin with 5 per cent. carbolic solution, I introduced needle at a point just outside of nipple line and in sixth intercostal space and withdrew fifty-five ounces of creamy pus. After the withdrawal of sixteen ounces Dr. Nason remarked that he could feel pulse at wrist and our patient said he was feeling much better. After removing all that would flow our patient was left in fairly comfortable condition; cyanosis had disappeared, pulse was rapid but fairly good and breathing was easy. I now concluded that this accumulation must have been in the pleura, as I did not think the pericardium could contain such a quantity, and while our patient was in fairly good

condition for next three days, yet there was evidence of reaccumulation. There was some return of dyspnea, slight elevation of temperature; so, on August fourth, our patient was prepared for operation with the intention of establishing free drainage by resection of a portion of rib. Preparation consisted in scrubbing chest with soap and water and application of 5 per cent. carbolic solution.

Patient being anesthetized (C. Ea. being used) Dr. McLaughlin giving the anesthetic and Dr. Nason assisting me. I introduced aspirating needle in ninth intercostal space in posterior axillary line, and withdrew about ten ounces of clear serum. I now withdrew needle and introduced it near point of former puncture in aspiration, and now withdrew pus. Leaving needle in place I made incision along sixth rib and extending forward to costal cartilage and resected about three inches of the rib, extending forward to cartilage; on opening pleura, only found small amount of clear serum. But as the needle was still in place I could see that it was in pericardium; so, after protecting the pleural cavity with gauze packing, I incised the pericardium and evacuated about three pints of pus. I could introduce my finger all around the heart and by pulling the cut surfaces apart could plainly see the heart. The pericardium was stitched to the wound and the pericardium flushed with normal salt solution, and introduced small piece of gauze for drainage. There seemed to be no adhesions of pleura or pericardium whatever. The pleura was infected and necessitated daily irrigation of pleural sac, and the pericardium was also irrigated daily for two or three weeks. Recovery was somewhat slow but perfect; wound was entirely healed at end of third month, and patient now enjoys as good health as before the sickness.

The infection of the pleural sac here demonstrated the importance of avoiding wounding the pleura in operations for drainage of the pericardium.

Dr. C. A. Ljunggren reports a case of purulent pericarditis which recovered after incision and drainage. He adds six cases to the list of thirty-five collected three years ago by Dr. J. B. Roberts. In this series of forty-one cases, sixteen recovered and twenty-five died. He advises the following rules of procedure in such cases. A considerable opening should be made in the pericardium, so as to enable the surgeon to obtain a view of the contents of the sac, and remove fibrous masses. In order to avoid injuring the pleura the incision should be kept within the zone of absolute dullness. In some cases it is impossible to avoid the mammary vessels; in such cases they should be litigated before they are cut. The operation which he advocates is the resec-

tion of a portion of the fifth rib in the left mammary line, aided in some cases by removal of the sternal end of the sixth costal cartilage. He separates the pleura by blunt dissection and sutures it to the wound in the chest wall, and insists that the operation should be done as soon as diagnosis is made.

Dr. J. B. Roberts says we should do an operation which will not open the pleural sac, but which will open the pericardium at the most dependent point, and at a point which will be the most dependent even after the sac has contracted. He thinks that this point is best obtained by resecting the fifth costal cartilage; after the cartilage has been resected the internal mammary vessels are either sutured or tied in two places and divided, and the pericardium exposed by blunt dissection, and incises the pericardium and sutures same to wound.

In conclusion will say that there is little or nothing contained in our text books on this subject, and what little I have been able to find is in the shape of case reports. But I think all operators who have had these cases to deal with are agreed on all essential points. First, the importance of early free drainage. Second, the importance of opening the pericardium in a way best calculated to avoid injury to the pleura and heart. The prognosis is good in uncomplicated cases.

DISCUSSION.

Dr. Graves: The doctor has given us a very interesting paper on this subject, and the results were certainly all that could be desired. Dr. John B. Roberts in his monograph on "Paracentesis Pericardii," recommends tapping and irrigating where pus is present. I think that a purulent pericarditis should be treated, as in this case, like an empyema, and that we should have no more hesitation in operating than in opening up the pleural sac. The fact that we are dealing with the seat of life should not deter us from operating, because it is only by heroic treatment that we can hope to effect a cure of these cases. This is a very unusual case, and it calls the attention of the general practitioner to the fact that this condition may exist in almost any case where there is disturbance of the heart. We are liable to meet such cases in our general practice at any time, and the medical literature upon this subject being so meager in regard to treatment, that we must to a great extent, take the matter into our own hands, and use heroic measures to effect a cure, and the diagnosis should not be very hard. I think that Dr. Gray deserves to be congratulated for his courage in dealing with this case. His results have certainly been all that could have been wished for, and without the radical treatment death would have been inevitable.

AMPUTATIONS OF THE FOOT.*

BY L. REYNOLDS, M.D., HORTON, KANSAS.

Surgical responsibility is much greater now than formerly, and only the strictest attention to every detail in the treatment of an injured limb can absolve the surgeon.

Owing to the great advantage of modern work in conserving nutrition of injured parts, indications which formerly justified amputation will not always do so now.

The removal of a limb or part thereof, except for manifestly clear indications, involves great professional and legal responsibility.

There are so much of tradition, and so many operative procedures with modifications all duly described and labeled, that one feels like beginning anew the study of the subject freed from such out of date encumbrances.

The light will begin to dawn when the eighteen or twenty un-American names are set aside and the anatomy of the foot regarded, so far as the skeleton is concerned, as a surgical unit, the same as any of the long bones.

Agnew taught this, and its application with the tailor's rule to act according to material on hand, forms a safe guide with but one exception. This exception applies when insufficient plantar tissues are saved to bear the body weight although other parts are sound. Such a condition justifies amputation above the ankle.

Neither cicatricial nor dorsal tissues will ever be satisfactory to sustain the body weight. Therefore the scar should always have a dorsal position out of the way of any considerable pressure.

Owing to the difficulty of applying artificial apparatus to parts of the foot, some prosthetic manufacturers have boldly advocated avoiding all tarsal and medio-tarsal amputations, or, in other words, never to amputate within three inches of the ankle joint in either direction.

The collateral circulation of the foot is less profuse than that of the hand, and necrosis of either hard or soft tissues or both is a possibility to be borne in mind. On this account the utmost economy of blood supply must be observed.

Trauma should be kept within the minimum limits in operating.

The fate of the limb and even life will frequently depend on the first dressing.

The essentials in all cases are healthy plantar flaps, thorough cleanliness, drainage and scar protection.

* Read at the Thirty-sixth Annual Meeting of the Kansas Medical Society, Lawrence, May 7-9, 1902.

Whenever the exigencies of conservative surgery demand it all typical operations should be disregarded.

There is no special advantage in following articular lines as formerly advised. Modern clean surgery enables us to ignore these.

It is well known that not the least of the difficulties in foot injuries is to preserve the nutrition of parts left after amputation.

Where the tarsus is extensively damaged leaving no bony structures available except the os calcis, tibia and fibula, I have practiced uniting the anterior extremity of the os calcis with that of the tibia without dissecting any soft tissues from articular margins to admit of the use of the saw on either bone. This method helps to preserve both length and nutrition. It is accomplished by cutting away, by means of a bone cutting forcep, the synovial membrane of the concave articular surface of the tibia and also that of the convex articular surface of the os calcis. The margins of the latter may be trimmed somewhat in order to offer a convexity that pretty accurately fits the concavity of the corresponding tibial surface, as the case herein reported illustrates.

All tarsal and mediotarsal amputations have one drawback in common—that of the action without counteraction of the tendo-achilles.

There are two methods of overcoming this, and both are applicable in most cases. Such cases as have the anterior and posterior tendons preserved may have their extensor ends united to the flexor ends thus preserving the balance.

In all tarsal and tarso metatarsal operations the large posterior tendon should be severed at the time of the amputation. This should be done subcutaneously and the foot brought into a well extended position. Extension should be carefully maintained by means of a posterior splint and an adhesive strap applied anteriorally over the dressing, the other end being attached high up on the anterior tibial surface.

Efficient drainage must be provided, carefully avoiding any dead spaces.

Always bear in mind the comparatively low vitality of ankle and foot structures and preserve all possible nutrition.

The following case illustrates a useful procedure which I have not known to be described or practiced elsewhere.

C. H., aged 27, a railroad brakeman, while trying to board a box car in motion, lost his foothold, allowing the foot to pass under the wheel, sustaining a crushing injury of all hard and soft tissues in front of the astrogalus whose anterior extremity was laid bare.

After trimming away devitalized tissues and irregular margins, I

found just sufficient sound plantar tissues to bring up and meet healthy dorsal tissues and place the scar out of harm's way.

Tendons could not be united owing to their extensive destruction.

Without dissecting away soft tissues from lower end of tibia and fibula with opposing end of os calcis to permit the use of a saw as commonly advised and practiced, I simply cut away articular structures and synovial membrane by means of a bone cutting forcep. This left the lower end of the tibia a smooth concave surface.

The articular surface of the anterior extremity of the os calcis was treated the same way, and in addition its articular margins were trimmed or bitten off causing a convex surface, which very accurately fitted the corresponding concave surface of the tibia.

These surfaces were brought into contact and maintained there until union occurred, making one bone of the two.

No saw was used and a greater length of limb was secured. The work was done at night with no professional assistance other than an anesthetiser, and in a country hotel.

Much less mutilation of soft tissues was done than in the cases of typical operation which would have required the removal of articular ends of both bones by means of a saw, creating much greater trauma to both hard and soft structures.

Free bilateral drainage was provided and healing was both rapid and gratifying.

A very useful and satisfactory stump is the result.

This case occurred more than three years ago.

Have purposely avoided the use of all the names of individuals so long connected with all typical surgical procedures in the foot, hoping thereby to simplify the subject.

DISCUSSION.

Dr. Axtell: I think the doctor has given us a very able paper, in which he has brought out all the new points of practical interest upon the subject. I like the paper that is not "text-booky," one that gives us the new things without having to bring in all the old ones.

Dr. Gray: I do not know as I have anything particular to add, more than to suggest the thought that most of these cases which come to us requiring amputation of the foot are usually of a class who will never wear an artificial limb. I believe that where it is at all possible to save a limb that will be useful without the use of an artificial foot, by all means it should be done, and all the foot should be preserved as far as possible.

APPENDICITIS.*

DR. M. C. PORTER, CLAY CENTER, KANSAS.

The veriform appendix is attached to the lower part of the caecum somewhat toward the posterior and inner aspect. Its length varies from three quarters of an inch to nine inches; its diameter is about that of an ordinary lead pencil. Its direction is most frequently downward and toward the median line, but it may occupy any direction, sometimes being retroperitoneal. Its structure resembles very closely that of the small intestine, being composed of an inner mucous coat, a sub-mucous, a muscular and an outer peritoneal coat. It is supplied with a meso-appendix which does not usually extend the full length of tne appendix, thus leaving a portion completely surrounded by the peritoneum. Its nerve, blood, and lymphatic supply are deficient and it is claimed by some authorities that it is the remains of a large cecal pouch, while others claim that it is in a state of arrested development, its development having ceased very early in infancy.

It would be impossible and also undesirable in the short time allotted me to go very deeply into the pathology of the vermiform appendix, and, while it is very nice to discriminate in the pathological laboratory between the different forms of appendicitis in the sick room such discrimination and classification are impossible in the vast majority of cases.

Appendicitis may be classified as acute and chronic. The acute form may be catarrhal, phlegmonous, necrosing—which may be perforating or non-perforating—and gangrenous. The chronic form may be classified as catarrhal, interstitial and obliterating.

Appendicitis occurs more frequently in males than females. The majority of cases occur before the age of thirty. In this connection might be stated that the appendix is very rich in lymphoid tissue, much more so in proportion than the large intestine. This tissue is found in the mucosa and submucosa where in the latter it seems to form almost a distinct layer. This is particularly the case in early life and it has been stated by some authorities that by the age of thirty the lymphoid tissue of the appendix has largely disappeared. Foreign bodies and fecal concretions seem to have something to do with causing this inflammation; although the effect of the former has probably been overestimated, while the latter has probably first been the result of the inflammation instead of the cause. Its presence, however, tends to keep up the trouble. Feats of strength, certain

*Written for the Kansas Medical Society.

athletic exercises, and traumatism have been ascribed as causes. In fact, anything which causes an infection atrium for the entrance of micro-organisms is a cause. The direct exciting cause is the entrance of pathogenic bacteria within the tissues of the appendix. The most important of these are the bacillus coli communis, staphylococcous albus and aureus, and the streptococcus pyogenes.

There are three symptoms which are so constantly present in the beginning of an attack of appendicitis, that they are very appropriately called the three cardinal symptoms. They are pain, tenderness on pressure and rigidity of the abdominal muscles over the region of the appendix. In the majority of the cases of appendicitis that have come under my observation the initial pain was referred to the epigastrium, shortly becoming diffused more or less over the abdomen and finally centering in the region of the appendix. There is almost always pain at McBurney's point. Although the appendix may be curled up along the outer side of the ascending colon, or attached to the left Fallopian tube, or pointing northeast toward the spleen, pressure at McBurney's point will almost always elicit pain. There is usually an increase of temperature from a very slight amount to as high as 104° or 105° Fahrenheit. The pulse is more uniformly affected than the temperature. However, I wish to call attention to and emphasize the fact that the pulse and temperature are of scarcely any use as factors in determining the gravity of a case of appendicitis, as I, at one time, had occasion to realize. This was the case of a young man suffering from appendicitis. I called to see him about midnight, on my way to the country, he having been placed in my charge two days previous. I found him with a normal temperature, pulse 80 per minute and feeling quite comfortable; in less than one hour he was dead. The autopsy revealed a subphrenic abscess of large proportions which had ruptured into the greater peritoneal cavity. There is usually, but not always, nausea which may or may not be accompanied by vomiting.

The diagnosis of appendicitis, when the three cardinal symptoms are present, is very easy. Acute abdominal pain, usually with, but sometimes without, nausea and vomiting, becoming localized in the right iliac region, and occurring in one previously well, tenderness on pressure and rigidity of the abdominal muscles in the region of the appendix points with almost absolute certainty to appendicitis. These symptoms are, I believe, more frequently present than appreciated, since the pain and gastro intestinal disturbances are not of such severity in all cases as to call one's attention to the appendix. One should, therefore, in all cases of gastro intestinal trouble, search

carefully for these symptoms; as a mild attack of appendicitis sometimes manifests itself to the casual observer as an attack of acute indigestion. While it is impossible in this short paper to say anything on the differential diagnosis of appendicitis, I desire to emphasize its great importance and insist that every one engaged in the practice of medicine should familiarize himself with every detail and be able to make an early diagnosis, for this is of the most importance in the successful treatment of the disease.

The treatment of this disease is primarily and essentially surgical. The so-called medical treatment is a delusion and a snare; and has lulled many a trusting victim into that sleep that knows no waking. Opiates should not be administered as they tend to mask the symptoms and hide the danger signals. Purgatives do harm. Gastric and rectal lavage are dangerous. The entire treatment of appendicitis can be embodied in the word operation. As to the time to operate, I know of no rule that meets all cases better than that of operating as soon as you make your diagnosis. This is of the utmost importance if the case is seen early while the lesions are yet confined within the appendix. This is the golden opportunity not only to cure the case with the least possible risk to life, but also to prevent the numerous complications and sequelæ which occur in, and follow, neglected cases; and which become much more dangerous and difficult to treat them than the original disease. It is impossible in a given case of appendicitis, to determine just what pathologic condition exists. We cannot say, always, whether we have an acute catarrhal, a phlegmonous, a gangrenous, or a necrosing appendicitis. Neither the pain, temperature, pulse, nor the constitutional disturbance gives much of a clue as to what is happening inside the appendix. If it were possible to determine the exact pathological condition, there would be numerous cases where delay would be safe. But in the present advanced state of our ignorance, we are not able to say in which case we may wait with safety, or in which delay is dangerous; but we do know that the removal of the vermiform appendix in uncomplicated cases of appendicitis is easily done and the danger very small.

Hence, I believe, it is better to remove a large number of slightly diseased appendices that might have undergone a "spontaneous cure" than fail to remove one that, if left alone, will cause the death of the patient. To the above rule there are few exceptions. In cases in an extremely septic condition with clammy skin, cold extremities, and feeble pulse, I do not think operation would do good. Again, it is well sometimes to consider the environment of a patient. The object

in operating is not to operate but to save life; and it sometimes happens that more lives may be saved by refusing to operate than by operating.

For example: In a desperate case occurring in a community prejudiced against surgery and the intelligence of whose people does not enable them to distinguish between the post hoc or the propter hoc, it would perhaps be wise for the surgeon to withhold the knife for fear that operation might be refused in favorable cases on account of the unsuccessful result in the unfavorable case.

DEATH following the rupture of a large tonsillar abscess is reported by Lyons. The case was that of a man 28 years old, who was admitted to the hospital with a suppurative tonsilitis on the left side. He was put to bed and given a warm drink. About half an hour afterward the nurse in charge heard him cough, and on going to investigate, found him cyanosed. When the physician arrived five minutes later, death had taken place. The post-mortem showed that the abscess had burst, and that a large amount of pus had got into the upper part of the larynx. The accident is a rare one, only one other case being reported in the literature.—*Medical Critic.*

RINGER is authority for the statement that a lotion of dilute nitric acid, ½ to 1 drachm to a pint of water, is of service in bleeding piles. It arrests the hemorrhage, constringes the parts and relieves the sensation of weight and fullness, often distressing symptoms.

IN attacks of angina pectoris, if accompanied by high arterial tension, nitrate of amyl is a quick and reliable remedy. Crush a pearl on a handkerchief and inhale a few whiffs.

IN the nervous disorders common at the menopause the bromides should be combined with valerianate of ammonium and given in moderate doses.

IN gastric ulcer, nitrate of silver combined with hyoscyamus or opium and given in pill form, is the best remedy.

Editorial.

THERE are some things about the medical law that seem a little unfair. According to the interpretation of the law as we understand it is held by the Board, a four-year course in medicine is the essential qualification for entrance to the examinations held by the Board. In lieu of one year of the four required, five or more years of practice will be accepted, but in no case will a course of two years be accepted as sufficient. A great many of the most prominent men in the medical profession are two-year graduates. Are these to be excluded from taking the examination if they so desire? There are good reasons for making these laws strict, but there are also good reasons for making them sufficiently elastic to admit those who are thoroughly qualified even though they may have been unfortunate enough to have graduated under a two-year requirement. Is not a long period of persistent study and experience equal to either two of the college years now required?

IN spite of the excellent results which have been reported from those using the X-ray in the treatment of malignant growths, there are features appearing which may greatly discourage its very general or extended application. Severe disturbances of nutrition, possibly due to absorption of the toxines resulting from the degeneration of the growth. At any rate death has resulted from the conditions following the use of the X-ray in some cases, not from the effects of the growth, but the secondary effects growing out of the changes produced by the X-ray.

ANOTHER matter in relation to medical registration in Kansas will probably come before the next Legislature. It is proposed to require an annual registration and a fee for registering. The physicians of the State should express their opinions on this matter as it concerns them alone. The amount collected in this way would put quite a little fund into the hands of the Examining Board which doubtless could be used by them to good advantage.

ONLY a few county societies have been organized, but it is to be hoped that some interest will soon be manifested. The officers of the Northeast District will take the matter up at once, and committees will be appointed in each county in the district. The membership in the State organization should be more than doubled during the present year.

THE Golden Belt Medical Society will meet in Topeka December 30th. A good program has been arranged and a large attendance is expected.

Miscellaneous.

PROF. LORENZ'S BLOODLESS REDUCTION OF CONGENITAL DISLOCATION OF THE HIP JOINT.

Edmund Andrews, M.D., LL.D., in the Illinois Medical Journal.

Much interest has been excited by the fact that a citizen of Chicago has called Prof. Adolph Lorenz, of Vienna, to come across the sea and reduce, by his bloodless method, a congenital dislocation of the hip joint in a child five years of age. The Professor came and operated successfully. During his stay he was invited to give clinics in Mercy Hospital and other institutions, where he applied his method to a considerable number of similar cases. As I observed his procedure closely, a condensed statement of the whole subject may be of interest.

Congenital dislocations of the hip joints are somewhat rare. When they occur it is the opinion of obstetrical authorities that the displacement of this joint takes place some time before birth, and almost never as an accident of the delivery. It appears to be due to imperfect development of the acetabulum, the head of the femur, and of the capsular ligament. In other words, the undeveloped mechanism of the joint allows the head of the femur to be gradually drawn or pressed upward and backward *in utero*, and before labor commences.

During the last ten years efforts have been made to treat these cases by two methods:

1. By incisions down to the joint.—Through the open wound the operator clears out the acetabulum and when necessary enlarges and deepens it by curetting and gouging the bone. He then places the

head of the femur in the enlarged cavity and closes the wound aseptically.

Dr. Hoffa reported 248 open wound operations with ten deaths. About half the operations were perfectly successful. Of the other half ten died, as above stated, and the remainder had more or less imperfection of the function of the joint.

2. The bloodless operation.—Prof. Lorenz, of Vienna, gave his attention earnestly to the development of this method. Five years ago he published a large number of cases, and since that many more. He seems to be a candid man. He admits failures and lays no claim to infallibility. He says that from 50 to 70 per cent. of the children obtain a perfect functional cure, so as to be able to run, jump, and use their limbs as well as anyone, but that anatomically the X-ray and other methods of examination detect in these successful cases some harmless deviation from perfect form or structure. The remaining cases, amounting to about 40 per cent., are usually greatly benefited, but still not functionally perfect.

Mickulicz, of Breslau, in Germany, has also published a large number of cases of the bloodless operation, and claims a very high success.

Lorenz's ideas and methods are as follows: The child should be allowed to reach an age above two years and not over five or six years before operating. In older children the operation becomes more difficult, and although some successes are obtained among them the ratio of failures is large. Prof. Lorenz brought with him from Vienna a highly trained assistant and several pieces of special apparatus to enable him to apply proper force to the limb and to hold the patient in desired positions.

Anaesthetics were given in full quantity. He remarked that it was of great importance to avoid haste in applying the necessarily great force, and insisted that one must proceed "*slowly—slowly*," so as to stretch and rupture the opposing muscles and ligaments very gradually, otherwise bones would be fractured. He says he has fractured the neck of the femur quite a number of nimes, but the shaft only once. His manipulations consist of flexions, rotations, tractions, and finally very great forced abductions, so as to put the three adductor muscles on a violent stretch and make them rise up a firm, hard ridge under the skin near their origin at the pubis. Then, while an assistant maintains this powerful tension by forced abduction, he manipulates this muscular ridge pretty near the pubis by a chopping motion of the border of the hand and the pressure of the thumbs and of the closed fist until by great force and determined persistence he tears off

the three great adductors from their origins at the pubis and ramus of the ischium. At the same time all the other tissues which resist extreme abduction are slowly stretched or torn until the femur is thoroughly loosened and the thigh can be swung freely out so as to stand out laterally at right angles to the axis of the body. This part of the operation gives an impression of terrific violence to one who sees it for the first time, and the necessity of judgment and skill in the operator is most manifest. The manipulations, rotations, and tractions are now patiently and adroitly continued until the head of the bone is felt and heard to snap into the acetabulum, or upon its rim, if the cavity is not large enough or empty enough to fully receive the head. If it is a double dislocation, both sides are treated in the same way, the bones are placed in position, with the two thighs standing out laterally at right angles to the body, for in no other position is it possible to keep the head of the femur down upon the acetabulum, because those cavities are in many cases very imperfectly developed.

The next step is to wrap the thighs, as well as the pelvis, thickly with cotton compactly bandaged on. Some strips of soft porous cloth are laid next to the skin under the cotton, and extending above and below it, for purposes presently to be mentioned. Next plaster of Paris bandages are applied over the whole length of both thighs and across the back and front of the pelvis, so that the pelvis and both of the thighs are encased in one inflexible mass. The knees and legs are left free. The strips of soft cloth laid next to the skin and running beneath the plaster dressing are used to cleanse the skin from time to time by pulling them to and fro, and are renewed as often as needful by sewing clean strips to the ends of the soiled ones and then pulling them into position. The anus and urinary outlets are left uncovered.

The plaster splint is kept on about six months, and sometimes longer, but the patient is allowed, after the first few days, to get out of bed and hobble about. When the splint is taken off the thighs are found, of course, to be standing out somewhat stiffly at right angles to the body. They must not be suddenly brought down, but by very slow and gradual manipulation from day to day, they are brought back to the line of the body. By this time the heads of the femur will be so well settled into the acetabula, either by adhesion or by repair of the capsular ligaments and synovial membranes, that they will remain there securely in most instances. In a few cases they will fail to preserve perfectly their correct position, but even then they are much nearer to it than before the operation, and much more useful for walking.

It is perhaps too early as yet to determine with absolute certainty the relative value of the two methods, but my belief is that Lorenz's bloodless operation will be found the safest, and will, on the average, give the most useful limbs.

American surgeons are favorably impressed with the personal qualities of Prof. Lorenz, both on account of his great skill in manipulation, and of his apparent honesty in admitting his failures when they occur.

Operations somewhat similar to his have occasionally been done by Chicago surgeons, but it was a great pleasure to see the method demonstrated by the one most distinguished as its author and developer.

CHRISTIAN SCIENCE IN NEW YORK STATE.

The *Brooklyn Medical Journal*, December, 1902, reports a case that is occupying the court of White Plains, N. Y. It seems that Esther Quimby, age 7 years, was under treatment by one Lathrop, a "Christian Science Healer," for diphtheria, and the child died. Assistant District Attorney Weeks, of Westchester county, has charge of the prosecution under clause 1, sec. 288, of the penal code, which reads: "A person who wilfully omits, without lawful excuse, to perform a duty by law imposed upon him to furnish food, clothing, shelter or medical attendance to a minor, or to make such payment toward its maintenance as may have been required by order of a court or a magistrate when such minor has been committed to an institution * * * is guilty of a misdemeanor."

At the inquest, it was disclosed that the dead girl's mother was ill with diphtheria, and that the girl's sister, Bessie, aged 16 years, and one of the older boys had diphtheria also. Mrs. Quimby was too ill to attend the inquest, but her husband and Lathrop, accompanied by several other prominent "Christian Scientists" of New York and Mount Vernon, were present.

Mr. Quimby testified that of his ten children three were living—the last to die being his daughter Esther. His older daughter fell sick on Sunday night. Esther was unconscious most of the time from Sunday 9 P.M., until about 8:30 A.M., Monday, when she "passed on." She did not choke, but there was some odor from the mouth. No hypodermic nor other treatment was used. She was a bright child and a believer in Christian Science, as are all of the family. The only treatment given Esther was "Christian Science." Both the

father and mother had the degree "C.S." in Christian Science, for which they had paid $100 at the Second church in New York, for instruction, which instruction was gleaned from the works of Mrs. Eddy. Quimby did not claim to be a practitioner, but had alleviated his own sufferings by the "Science." Mrs. Quimby, however, was a "healer," and had "healed" some of her neighbors or friends, for which he always charged. When their oldest daughter, Bessie, was taken ill, she exerted her powers, and then they employed a "healer," Lathrop, who stands "very high" in the science. He said the children had tonsilitis, and so did Quimby and wife think. Lathrop's fee was his railroad fare and $1 for each treatment. When Quimby, on Sunday night thought Esther had diphtheria, he telephoned Dr. Birch and asked if it would be wise for him to go into the room and afterwards go to work? Dr. Birch testified that he asked Quimby how he knew that Esther had diphtheria, when he answered that the "healer" believed it was, and had advised Quimby to notify the Board of Health. Dr. Birch examined Mrs. Quimby, Bessie and the son, and found each affected with false membrane, etc. Autopsy of Esther, held by Dr. Geo. C. Weiss, revealed diphtheria unmistakably. Dr. Edward S. Newell made bacteriological examination, and found diphtheria germs in great abundance. He also testified as to the efficacy of antitoxin.

On October 30th the grand jury indicted the "healer," Lathrop, and Mr. and Mrs. Quimby on charge of manslaughter in second degree, and their bonds for appearance at the next session of the court were recognized. The indictment charges the parties with "maliciously and feloniously" causing the death of Esther, by neglecting to provide medical attendance, etc. If found guilty, the law does not allow the magistrate any latitude, but imposes a prison term of 15 years or a fine of $1,000, or both.

Coroner Banning, who has pushed the movement against "the healers" to its present stage, looks upon the indictment as a big victory, and he is backed by the medical societies. It is not thought the accused will ask a change of venue, but it is not likely that any resident of White Plains will sit on the trial jury. What the defense of the Christian Scientists will be is unknown; but it is probable they will force the court to show some law compelling persons to swallow medicine.

With the indictment, the grand jury delivered to the court the following presentment: "The attention of the grand jury has been been called to an evil existing in the county of Westchester, which we deem a source of danger to the health of the community. Our

attention has been directed to the treatment of infectious and contagious diseases by persons who are not regularly licensed physicians and surgeons, where the rules of the local and State Boards of Health are violated.

"We have given careful consideration to a complaint made to us concerning the death of a seven-year-old child from neglect, the child being treated by a so-called Christian Science healer from the city of New York, who made many visits to the home of the child, and mingled with the inhabitants of the county both upon the streets and in public conveyances. This child was allowed to die without any of the remedies known to medical science being used, and medical men called before us testified that the life of the child could have been saved had proper treatment been used and proper remedies applied.

"This so-called Christian Science treatment was used at the instance and request of the parents of the child, the father daily attending to business after nights spent in the sick room. This child was allowed to attend school while an older sister was sick in the house. The attention of the local Board of Health was not called to the case until a few hours preceding the death of the child.

"We feel that flagrant violations of the health laws in this respect should be sought out by the local Boards of Health throughout this county, and respectfully request that a copy of this presentment be sent to the State Board of Health, and to the several Boards of Health in this county, to the end that quarantine regulations be more strictly enforced and the danger of the spreading of infectious and contagious diseases be lessened."

This presentment of the Westchester connty grand jury, if it does not conform to the laws of any of the other States, is so filled with common sense and good judgment that we sincerely hope to see laws enacted in such other States as will protect the people from this craze of some persons and trickery of a large number of others. Life and health are too precious to each owner of them to be trifled with by quacks, charlatans, imposters, etc. There are too many sad stories of such impositions. For instance, Miss Louise Hoge, of Evanston, Ill., died November 12, in Washington, D. C. She had been ill for almost a month, suffering from typhoid fever, and was under treatment by a "Christian Science healer." An official autopsy was held.

It is true the *Christian Science Sentinel*, the official organ of the "healers," has ordered that "until the public thought becomes better acquainted with Christian Science, the Christian Scientists shall decline to doctor infectious or contagious diseases." But how is the

Christian Scientist to diagnose between these and other diseases unless he is a student of medicine and knows the principles of diagnosis? Such impositors should all be compelled to pass satisfactory examinations before their respective State Boards of Medical Examiners.

NEUROLOGY.

Medical Critic.

A very interesting paper entitled "A Contribution to the Radical Cure of Exophthalmic Goitre, with the Ultimate Results in Eight Cases Treated by Thyroidectomy," was read by Dr. J. Arthur Booth at the last annual meeting of the American Neurological Association, and was published in the *Journal of Mental and Nervous Diseases* for September, 1902. The author adopts three classifications of the cases of the disease in an attempt to explain the different grouping of symptoms: (1) those cases that depend on changes in the central nervous system, (2) those that are due to disease of the cervical sympathetic, and (3) those that arise from excessive or altered function of the thyroid gland. In cases belonging to the first class, distinct lesions in the medulla have been found at autopsies. Again, disturbances of the vagus at its central origin in the medulla, resulting in the tachycardia; the occurrence of the malady in cases where no goitre exists and no evidences are found of disease of the sympathetic; and the frequency of sudden death ascribed to minute hemorrhages, are all strong arguments for the establishment of this class or subdivision of cases. Autopsies on cases referred to the second class show lesions of the sympathetic, and especially of the inferior cervical ganglia; and there are numerous recoveries raported after operations on the sympathetic. Booth quotes Rehn, of Frankfort, as reporting 32 cases of resection of the sympathetic, of which 28.1 per cent. were cured, 50 per cent. were improved, 12.5 per cent. were unimproved, and 9.3 per cent. died. Jennesco, of 15 cases, reports 6 which were cured, 4 which improved, and 5 as yet undetermined, with no deaths, all after resection of the sympathetic.

In Booth's third class of cases are included those arising from excessive or altered function of the thyroid gland. Enlargement of the gland exists, and the vascular structures are much in excess. Booth gives the following figures: Schultze and Rehn, with 319 cases, report 175 cured by partial thyroidectomy, 89 improved, 13 unimyroved, and 41 deaths. Renbach, of Breslau, reports 18 cases from the clinic of

Mikulicz, which had been treated previously for a year with internal medication. Of these, 10 recovered after thyroidectomy, and one died of secondary hemorrhage. The other seven were markedly improved. Kummel, of Hamburg, reports upon 177 patients who submitted to the operation of thyroidectomy. Of these, 57.6 per cent. were cured, 26.5 per cent. were improved, and 2.3 per cent. were unimproved, and 13.6 per cent. died.

Booth reports 8 of his own cases, upon whom partial thyroidectomy was done, detailing all the symptoms and describing the condition very closely. Of these cases, 6 were permanently cured, one was improved, and one died 24 hours after the operation, with albumen and casts in her urine, though previously to the operative procedure her urine appeared normal.

Booth comments upon the difficulty of separating the individual cases into groups, in order to select the proper operative measure; but thinks that due consideration of the onset and course of the disease, study of heredity, and careful noting of the first symptom to appear, will probably result in accurate classification. He lays stress on the recognition of three factors in the production of the disease: (1) the central nervous system; (2) the connecting fibres, sympathetic and vagus; (3) the thyroid gland. He adds that a lesion in any one of these parts may produce a specific alteration in the others, the consequences of which, together with the exciting cause, may give rise to the symptoms of exophthalmic goitre.

POINTS OF SIMILARITY AND DIFFERENCE IN THE ONSET OF TYPHOID FEVER AND APPENDICITIS.

The Virginia Medical Semi-monthly.

Dr. Wm. Francis Campbell, Professor of Anatomy, Long Island College Hospital, etc., read a strong paper on this subject during the meeting of the Associated Physicians of Long Island, October 18, 1902, which we find in the *Brooklyn Medical Journal*, December, 1902. He says that appendicitis is conceded to be a surgical disease. To treat it medically is to play a game of chance. Radical removal is the rational remedy.

Appendicitis does not simulate other diseases, other diseases simulate it. In this class, typhoid fever plays an important role.

Classical typhoid does not simulate appendicitis, but an atypical variety seemingly presents many of the features of appendicitis. Atypical typhoid is not rare, and is often found in ambulatory cases.

In such cases we may have apparent sudden onset, diffuse tenderness in the right iliac region, elevation of temperature, increase of pulse. Such a group of symptoms naturally directs one's mind to the appendix.

In differentiation, consider—

1. The History.—Close and careful investigation will usually show that the apparently sudden symptoms were really preceded by days or weeks of certain prodromal symptoms, like headache, backache, malaise, etc., unrecorded by the patient and almost forgotten in the sudden abdominal symptoms. In appendicitis, there are no prodromata. The attack is sudden, abrupt, acute in a patient previously well.

2. Pulse and Temperature.—To put it tersely, the point of impression in typhoid is the temperature; in appendicitis, it is the pulse. True, we have elevation of temperature in both, but the relation of pulse to temperature is the important point. In typhoid, the pulse is relatively slow in relation to temperature; in appendicitis, it is usually rapid, and if the appendicitis continues, remains rapid though the temperature may come down to normal.

3. The Tongue in typhoid is usually characteristic. It is the dry, glazed tongue never seen in appendicitis.

4. Pain and tenderness are similar in both affections—sudden abdominal pain localizing in the right iliac fossa. We may not get the pointing of pain so sharply defined in typhoid as in appendicitis, but there is no point of appreciable differentiation in the pain. The tenderness in typhoid is a general regional tenderness; in appendicitis, you can often put the finger over a particular point of tenderness. Concisely stated: In typhoid, general tenderness of particular region; in appendicitis, special point of tenderness in particular region.

5. Muscular rigidity.—Of the three cardinal symptoms of appendicitis—pain, tenderness and rigidity—rigidity is frequently of most value in differention of other diseases from it. In the 15 cases of atypical typhoid studied, rigidity of the right rectus is not once recorded. Sometimes a "general rigidity," and again, "a boardy feel" to the abdomen have been recorded in typhoid. But this absence of right rectus rigidity in other abdominal lesions simulating appendicitis is very characteristic; so that we may regard rigidity of the right rectus muscle as a symptom of much importance and indicative of appendicial inflammation.

6. The Blood.—Blood examination is of inestimable value. Cabot says: There are few diseases in which the blood count is so often of value in diagnosis as typhoid. The blood count is to determine the

presence or absence of a leucocytosis. Local inflammatory processes have leucocytosis. Typhoid does not. Though chart and symptoms may point to typhoid, persistent leucocytosis means an inflammatory focus. In 45 cases of appendicitis in the Massachusetts General Hospital, leucocytosis was found in every case. This means of diagnosis is too little used to be appreciated. It will often confirm what other symptoms suggest.

The Widal reaction and the serum test of typhoid are purposely omitted in this discussion, since the former is of little value at the onset, and the latter of variable value in adults.

No isolated symptom can make a diagnosis; a proper number of suggestive symptoms are necessary for conviction. Of these, rigidity of the right rectus and a blood count are the most important points of diagnosis in favor of appendicitis, and are most decisive.

Tabulated symptoms are often of value and helpful when rightly used. A Table of Differentiation of symptoms in typhoid fever and appendicitis might read as follows:

TYPHOID FEVER.	APPENDICITIS.
Previous history (prodromata).	No previous history.
Onset only apparently sudden.	Onset really sudden.
Tongue dry and glazed.	Tongue coated.
Temperature elevated (stationary).	Temperature elevated (fluctuating).
Pulse slow in relation to temperature.	Pulse rapid in relation to temperature.
Pain in right iliac region.	Pain in right iliac region.
General tenderness of a particular region.	Special point of tenderness of particular region.
Rigidity general if present.	Rigidity confined to right rectus.
Leucocytosis absent.	Leucocytosis present.

THE ROENTGEN RAYS IN LUPUS VULGARIS.

Medical Progress.

Scholtz reports fifty-five cases of this disease which were treated during three years. The conclusion is reached that this method often has a decided superiority over the old methods, and appears to conduce more to permanent healing. This is especially true of lupus of the nose and lip, in which the mucous membranes are involved. Other advantages are the good cosmetic results and the painlessness. Disadvantages are the long duration of the treatment and the difficulty of carrying it out. It is believed that exposures causing inflammatory reaction, and even to some extent necrosis in the diseased parts, should be used in a certain number of the cases—not in all. The best

results, comparatively, were in the cases of severe lupus, which were not adapted to the usual methods of treatment, and in which the Roentgen ray exposures were energetically carried out. In sycosis and folliculitis barbe the rays seem to exert a favorable influence on the tissue, and some observers have seen a sinking down of the nodules and papules before the hair fell out. In all these cases the method was so used that the hair fell without essential signs of inflammation after about two weeks. Acne vulgaris and acne rosacea (nine cases) were improved, but not to such a degree as to put this treatment before the usual methods. Eczema (eight cases) was frequently very favorably impressed (the variety is not stated). Itching, oozing, and scaling were diminished.

The results in psoriasis are considered as very interesting. Twenty-six cases were treated. Weak exposures at pretty long distances were used. At first the treatment was repeated every day; later, every second or third day. In all cases the affection was much influenced; in most the lesions were entirely removed. Improvement began after three or four sittings. It is recommended, however, to hurry the cure later on by the addition of other methods. Nothing definite can be said as to recurrences. In one case such a recurrence occurred during the use of the method.

Codman contributes a most valuable and interesting article on the occurrence of dermatitis from the Roentgen rays. He has been able to collect less than 200 cases, from which he concludes that only one case in 5,000 has been injured, and less than half of these seriously. In 20,000 cases in the Boston hospitals there has been no dermatitis in patients, and but four in skiagraphers. Codman concludes that the frequency of dermatitis from the Roentgen rays has been much exaggerated, and that of the cases of injury more than two thirds occurred in the first two years of the use of this method. He considers that the cause of the injury, although not definitely known, is some form of energy closely allied to the photographically active X ray, and that the primary injury is to the nerves that control the nutrition of the skin, there being no good evidence that deeper structures are affected unless there are primary lesions of the skin. Idiosyncrasy, he considers, plays an important part. He agrees that hard tubes produce a less intense effect on the tissues than soft. Ten minutes' exposure at six inches from the platinum terminal is suggested by the writer as a standard therapeutic exposure. The dermatitis does not appear after three weeks from the last exposure; in one-third of the cases the dermatitis appeared within the first four days; in one-half before the ninth day.

Pusey considers that two of the properties of the X-rays, namely, their power of causing atrophy of the cutaneous follicles, and of checking pus formation, furnish good grounds for their use in case of acne.

He details the result of the treatment of eleven consecutive cases by this method. All of these cases were exposed to a very weak light, using a rather soft tube. The treatment was stopped at the first sign of pigmentation or erythema, and in no case did improvement fail to appear simultaneously with these appearances. The result in all of the cases was so direct and constant that there could be no question that it was due to the effect of the rays. In every case that has been under treatment for a sufficient time, Pusey has been able to see a beneficial effect. In these experiments all other treatment was avoided.

MODERN METHODS OF COMBATING TUBERCULOSIS.

Medical Summary.

It is amazing that the struggle against a disease which has received more attention than any other malady should be so slowly and seemingly hopeless. The bacteriologists have outlined the plans of the campaign, but the rank and file of the profession are too ignorant or negligent to step into the breach and hurl back the "great white plague," which sends more human beings beneath the sod than any other disease. If we had not the knowledge with which to ward off the attack, it would be deplorable, but when we have such knowledge and fail to use it is egregiously criminal, and we are traitors to our great profession and to all humanity.

We know the germ; we know how to kill it; we know partly how to avoid it if living and virulent; but because the laity are indifferent to their lamentable ignorance, we are discouraged, and teach and fight no longer. There are many things we do not know of the germ and its habits and tenacity of life. We will mention a few.

We teach our patients that heat kills the germ. A roasted joint of tuberculous beef may be safe on the outer, but the inner part may reek with virulent germs. The experience of Dr. Sims Woodhead, (Tuberculosis Hillier), proves that cooking is totally unreliable, since the ordinary cooking or roasting heat is proven to be only efficient for germ destruction on the superficial portions, and valueless in the deeper layers of the meat. It is generally conceded that meat may be infectious, and that it may be rendered sterile by cooking, and thus we err. When we know that tuberculosis is communicable from man

to man, and from animal to man, we should see that preventive measures are instituted. Tuberculosis is the Nemesis of departure from normal conditions, and the successful remedy for the malady must rest in a return to normal conditions. Its annihilation is both a social and a medical problem. All *Summary* readers ought to enlist "for three years, or during the war." Our path is made plain, if we but follow it. Let every man go to work to battle with the past, and we would soon have the victory. The fact that there is no such thing as "congenital tuberculosis" ought to hint something. Let us protect the helpless. If we cannot cook the meat, we may forbid the use of suspicious milk. Tuberculosis milk is the most deadly of all slow poisons, and we ought to investigate and control the product of all dairymen who serve our patients. Almost all the evil, and sin, and misery in the world is somebody's fault. The perfect disinfection of hospitals is admirable, but what shall we do with the consumptive patient in the country who knows that pure air is all she needs?

We must teach and command that since the sputum is infectious it must be destroyed; we must supervise the milk supply; we must coax family and patient to undertake systematic disinfection of the patient's room; we must understand that we cannot be good doctors till we are careful students, and when we strive to do our duty in reasonable knowledge of what we ought to do, we will fall in line with the front rank of practitioners, and surprisingly soon we will accomplish forever the conquest of the "great white plague."

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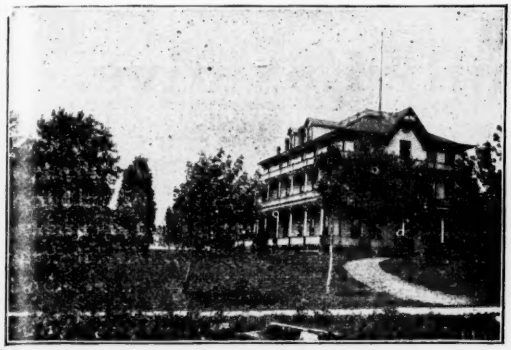

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